NORTHWEST TERRITORIES CORONER'S SERVICE 2006 ANNUAL REPORT

OFFICE OF THE CHIEF CORONER

September 30, 2007

Donald M. Cooper, Q.C., Deputy Minister
Department of Justice
Government of the Northwest Territories
Yellowknife, NT X1A 2L9

Dear Sir:

It is my honour to submit the Northwest Territories Coroner's Service 2006 Annual Report for the year beginning January 1, 2006 and ending December 31, 2006.

Yours truly,

Percy A. Kinney
Chief Coroner
Northwest Territories

Box 1320 Yellowknife, NT X1A 2L9 • 873-7460 PH • 873-0426 FAX

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HISTORY OF CORONER'S SERVICE

The office of the Coroner is one of the oldest institutions known to English law. The role of the "coroner" in England has been noted in references dating back to the time of the Saxon King Alfred in 925 A.D. However, the historical development of the office can be traced back to a time near the Norman Conquest when the Coroner was to achieve an important role in the administration of justice.

It is generally accepted that the office was not regularly instituted until the end of the 12th century. One of the first detailed statutes concerning coroners was the Statute of Westminster of 1276. The title of the office has varied from "coronator" during the time of King John to "crowner," a term still used occasionally in Scotland.

One of the earliest functions of the Coroner was to enquire into sudden and unexpected deaths where in some cases, a fee was to be paid to the crown. The Coroner was charged with the responsibility of establishing the facts surrounding a death, a duty that provides for the basis for all coroner systems in use today.

The *Coroners Act* established the territorial jurisdiction of the Coroner. The duties of the Coroner have been modified over the centuries, however the primary focus continues to be the investigation of sudden and unexpected deaths. With the growth of industrialization in the 19th century, social pressure demanded that the Coroner also serve a preventative function. This remains an important element of the Coroner's Service.

There are two death investigation systems in Canada: the Coroner system and the Medical Examiner system. The Coroner system has four main roles to fulfill: investigative, administrative, judicial and preventative. The Medical Examiner system involves medical and administrative elements. The Coroner and the Medical Examiner both collect medical and other evidence in order to determine the medical cause and manner of death. The Coroner receives the information from a variety of sources. The Coroner examines the investigative material, sorts out facts and comes to a judicial decision concerning the death of an individual. The Coroner can also make recommendations that may prevent a similar death.

In the Northwest Territories, the Coroner's Service provides a multi-disciplinary approach to the investigation of death by lay coroners appointed by the Minister of Justice. NWT coroners are assisted by the Royal Canadian Mounted Police and a variety of other experts when required.

INTRODUCTION

The Coroner's Service, for organizational and administrative purposes, falls within the Department of Justice. The Chief Coroner is located in Yellowknife and oversees all death investigations. Currently, there are 38 appointed coroners throughout the Northwest Territories. They provide service in the communities and regions in which they reside.

In the Northwest Territories, all sudden unexpected deaths must be reported to a coroner. The Coroners Service is responsible for the investigation of all reportable deaths in order to determine the identity of the deceased and the facts concerning when, where, how and by what means the deceased came to their death. The Coroner's Service is supported through efforts by the Royal Canadian Mounted Police, Fire Marshall's Office, Workers' Compensation Board, Transport Safety Board and various other agencies who work closely with the Coroner's Office.

The current Chief Coroner is Percy Kinney. A coroner in Yellowknife since 1993, he has occupied the position of Chief Coroner since February of 1998. However, the position of Chief Coroner will be vacant as of October 1, 2007

The Deputy Chief Coroner is Cathy Menard. Ms. Menard joined the Coroner's Service in February of 1996. She has been with the Department of Justice for over 20 years.

There are no staffed facilities in the Northwest Territories to perform autopsies. When an autopsy is required, the body is transported to Edmonton for the procedure. Following the post mortem, the remains are sent to Foster & McGarvey Funeral Chapel, under contract for preparation and repatriation. Toxicology Services are provided to the Coroner's Service by Dynacare Kasper Medical Laboratories in Edmonton and on occasion by the Chief Medical Examiner's Office in Alberta.

MANNER OF DEATH

All Coroner Reports and Jury Verdicts determine the manner of each death. All deaths investigated by the Coroners Service are classified in one of five distinct categories: Natural, Accident, Suicide, Homicide or Undetermined.

NATURAL covers all deaths primarily resulting from a disease of the body and not resulting from injuries or abnormal environmental factors.

ACCIDENTAL covers all accidental deaths including motor vehicle incidents where there is no obvious intent to cause death. This classification includes any death resulting from an action or actions by a person which results in the unintentional death to him/herself or any death to any person that results from the intervention of a non-human agency.

SUICIDE refers to any death from a self inflicted injury where there is apparent intent to cause death.

HOMICIDE includes any death resulting from injuries caused directly or indirectly by the actions of another person (with the exception of unintentional motor vehicle accidents). Homicide is a neutral term that does not imply fault or blame.

UNDETERMINED is any death which cannot be classified in any of the other categories. The actual cause of death may or may not be known in these cases. An example of an undetermined death would be a drug overdose were it is unclear if the victim intended to die.

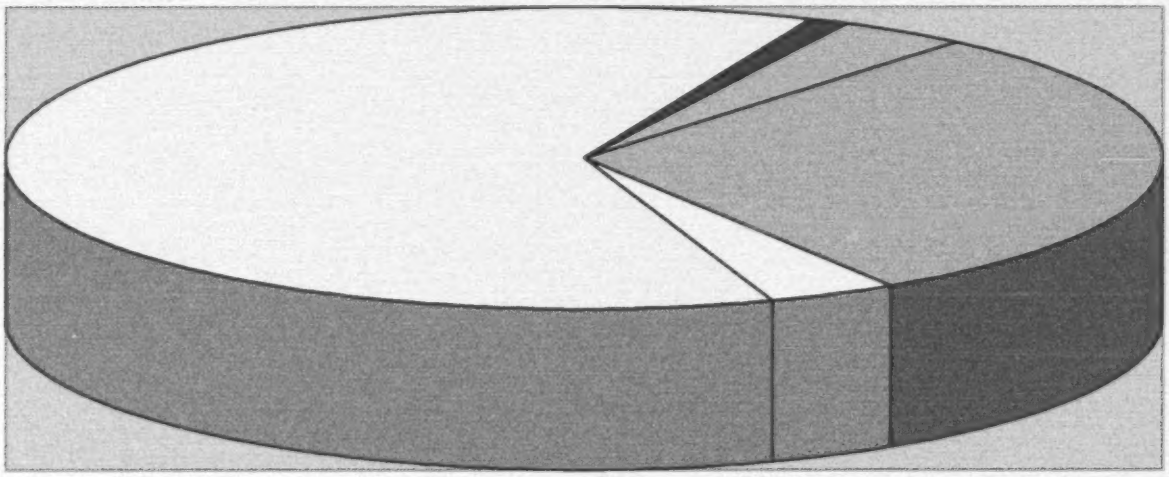
Coroners are instructed to make every effort to classify a death in one of the other existing categories before considering a classification of undetermined.

*(**UNCLASSIFIED** is reserved for any case work that ultimately does not result in another classification. It is primarily used for found remains which are analyzed and determined to be non-human.)*

CASE STATISTICS

TOTAL CASES

Manner of Death	Number	Percent %	Population %
Accidental	32	30.00	.077
Homicide	0	0.00	.000
Suicide	4	3.73	.010
Natural (includes Non-Coroner cases)	66	61.59	.159
Undetermined	1	.940	.002
Unclassified	4	3.74	.010
TOTALS	**107**	**100.00**	***.258**



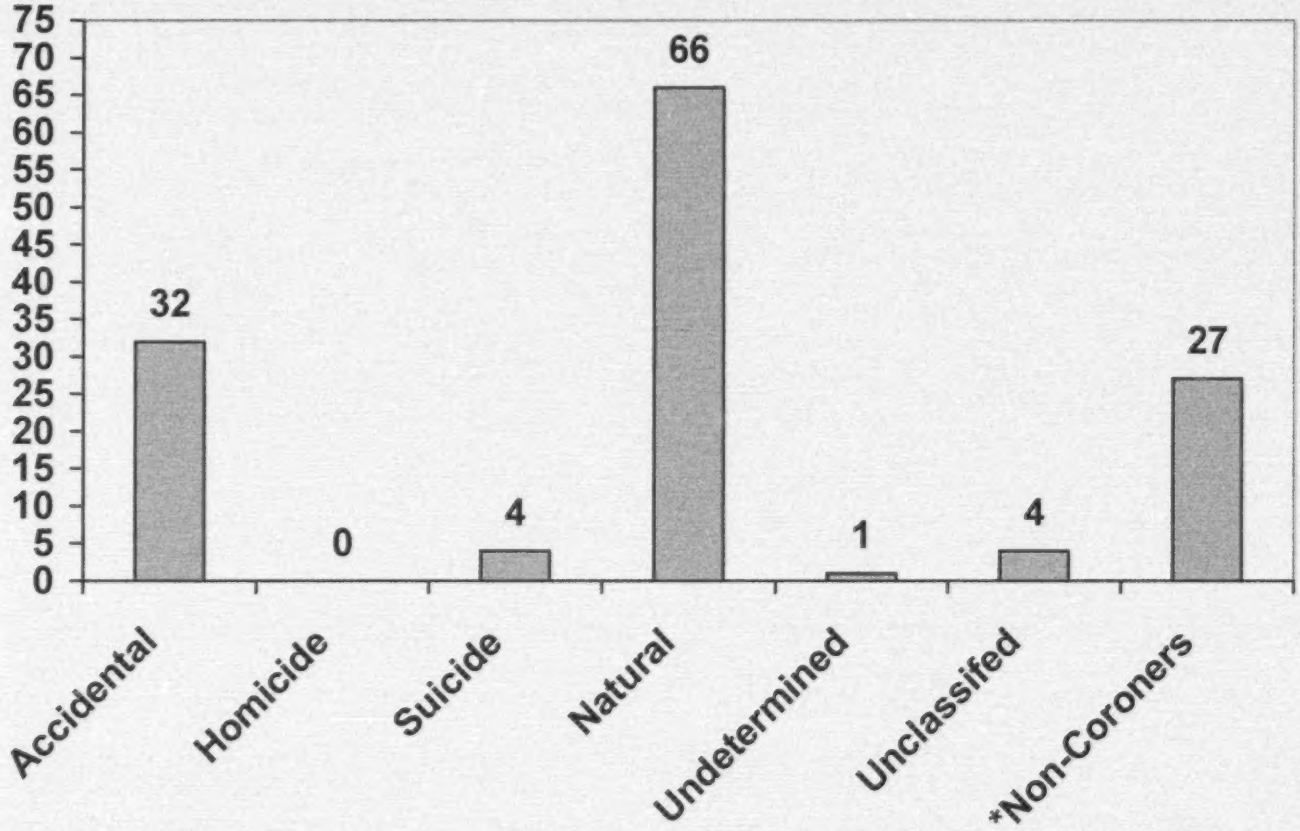
Accident 32 Homicide 0 Suicide 4
Natural 66 Undetermined 1 Unclassified 4

Non-Coroner cases are natural deaths that are reported to the Coroner's Service but do not fall under the reporting criteria required under the Coroner's Act. They must therefore be "Natural" in manner.

Unclassified cases are not represented in the population figures since they are non-human in nature. They do however make up 3.74% of cases investigated

- Based on 41,464 population re: stats.gov.nt.ca for 2006

CASELOAD BY MANNER OF DEATH



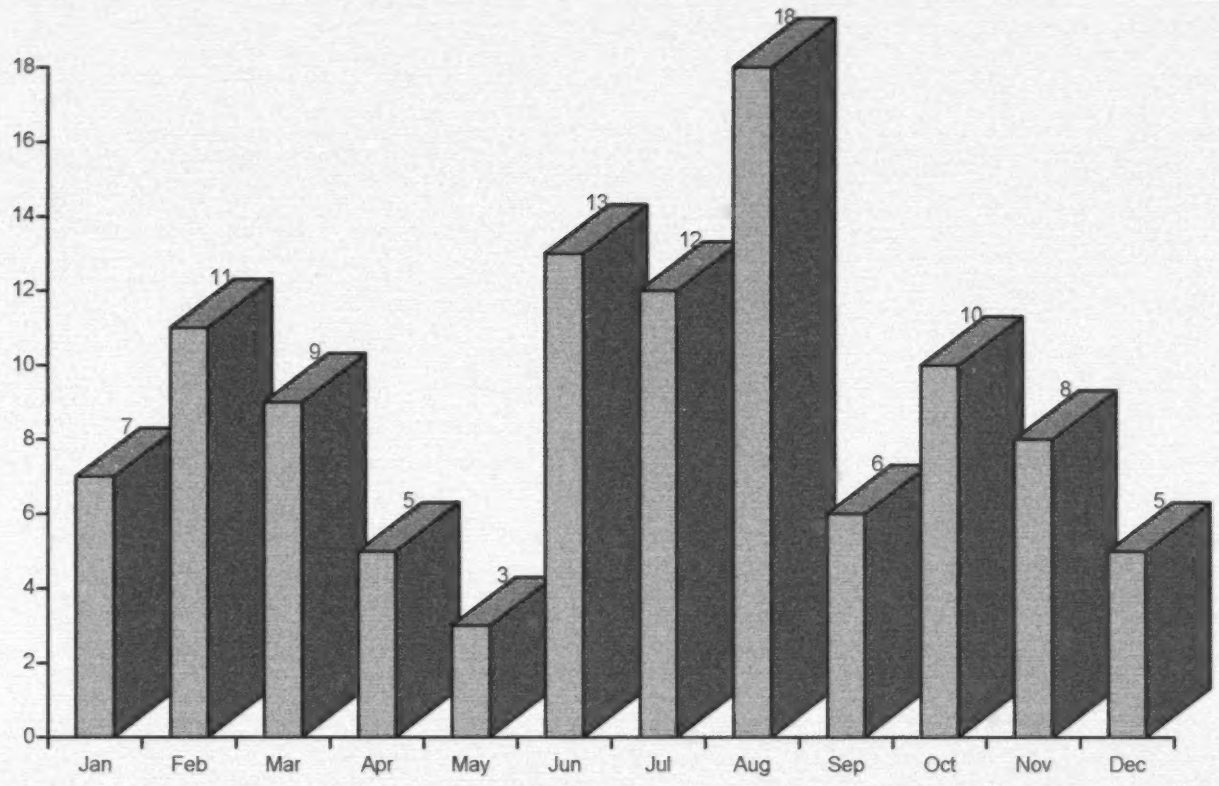
*The 27 non coroner cases are also included in the natural case load of 66

CASELOAD BY MANNER OF DEATH/COMMUNITY

Community	Accidental	Homicide	Suicide	Natural	Undetermined	Unclassified	Non-Coroners	Total
Nahanni Butte							1	1
Aklavik				1		1	1	3
Wha Ti	1						1	2
Fort Liard							1	1
Gameti	1							1
Norman Wells	3							3
Holman							2	2
Tulita	1*			1			1	3
Deline				1			2	2
Fort McPherson	4		1	1				6
Fort Providence	1			1			1	3
Fort Simpson	2			1				3
Fort Smith	2*			2				4
Fort Resolution				1			2	3
Hay River	3*			2			2	7
Inuvik	1			8				9
Tungston Mine				1				1
Rae/Edzo	1			3			3	7
Tuktoyaktuk			1			2	1	4
Tsiigehtchic	1							1
Paulatuk				1		1		2
Fort Good Hope	6+			1			1	8
Yellowknife	5		2	14	1		8	30
TOTALS	**32**	**0**	**4**	**39**	**1**	**4**	**27**	**107**

*one of each of these occurred in Edmonton
+ all of these were the result of a single airplane crash

CASELOAD BY MONTH



CASELOAD BY MANNER/MONTH

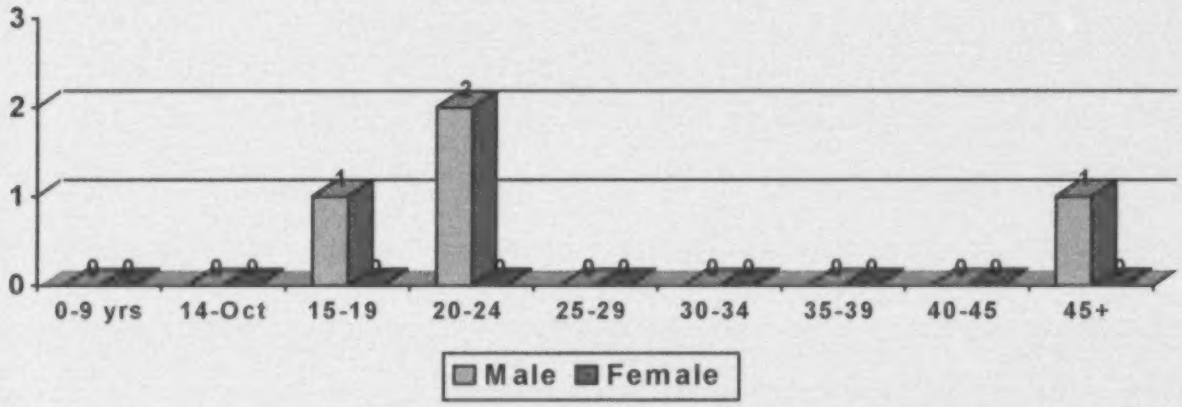
Month	Accident	Homicide	Suicide	Natural	Undetermined	Unclassified	Non-Coroners	TOTALS
Jan	2			3			2	7
Feb	1			3		1	6	11
Mar	2			4	1		2	9
Apr	1			2			2	5
May	1		1	1				3
June	4			2		2	5	13
July	5		1	4			2	12
Aug	9		1	6		1	1	18
Sept	1		1	5				6
Oct	4			3			2	10
Nov	2			3			3	8
Dec				3			2	5
TOTALS	**32**	**0**	**4**	**39**	**1**	**4**	**27**	**107**

SUICIDE BY GENDER/AGE

Age Group	Male	Female	Total
0-9 yrs			
10-14 yrs			
15-19 yrs	1		1
20-24 yrs	2		2
25-29 yrs			
30-34 yrs			
35-39 yrs			
40-44 yrs			
45 + yrs	1		1
TOTALS	**4**		**4**

Of the 4 suicide deaths in 2006, all were male, 2 of the suicides occurred in persons 20-24 years of age.

The suicide rate had remained fairly consistent over the last 4-5 years. This is the second consecutive year with a significant drop in suicide numbers and the lowest fiqure seen in several years. (5 deaths in 2005, 10 deaths in 2004, 12 deaths in 2003, 9 deaths in 2002, 10 deaths in each of 2001 and 2000, 16 in 1999, 7 in 1998, 6 in 1997, 5 in 1996 and 7 in 1995).

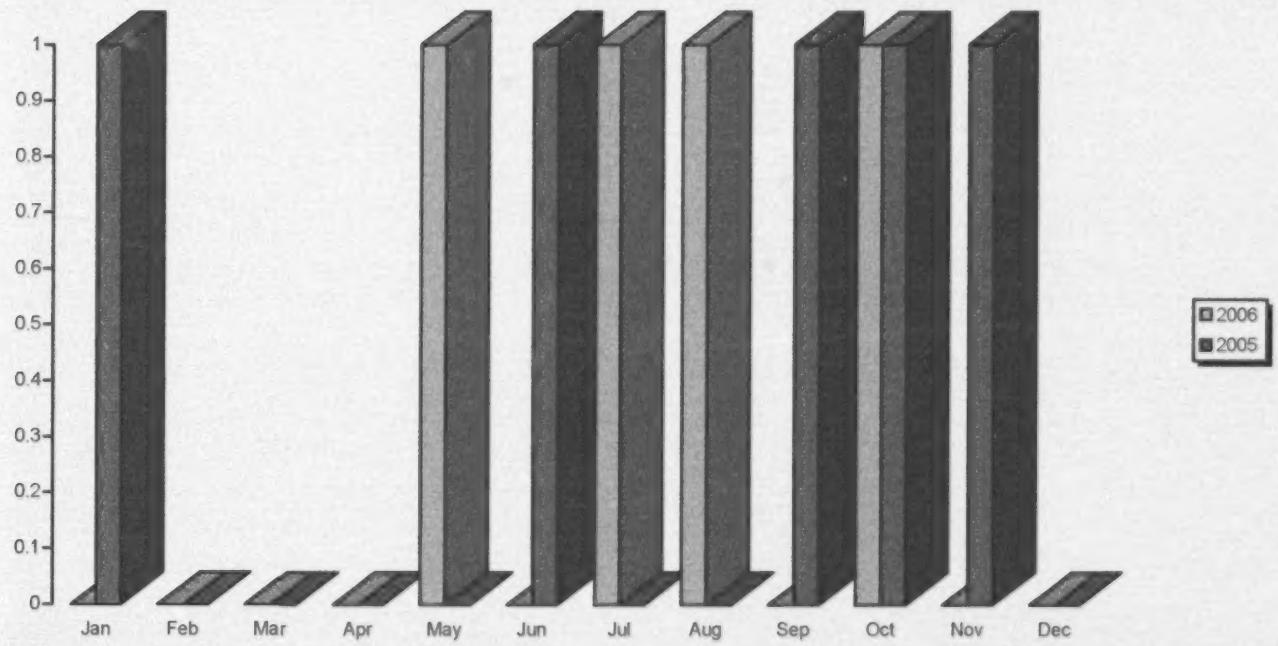


SUICIDES BY MONTH/COMMUNITY/GENDER/AGE/METHOD

Month	Community	Gender	Age	Method	Alcohol
May	Yellowknife	Male	55	hanging	no
July	Fort McPherson	Male	20	firearm	yes
August	Tuktoyaktuk	Male	20	firearm	yes
October	Yellowknife	Male	17	hanging	yes

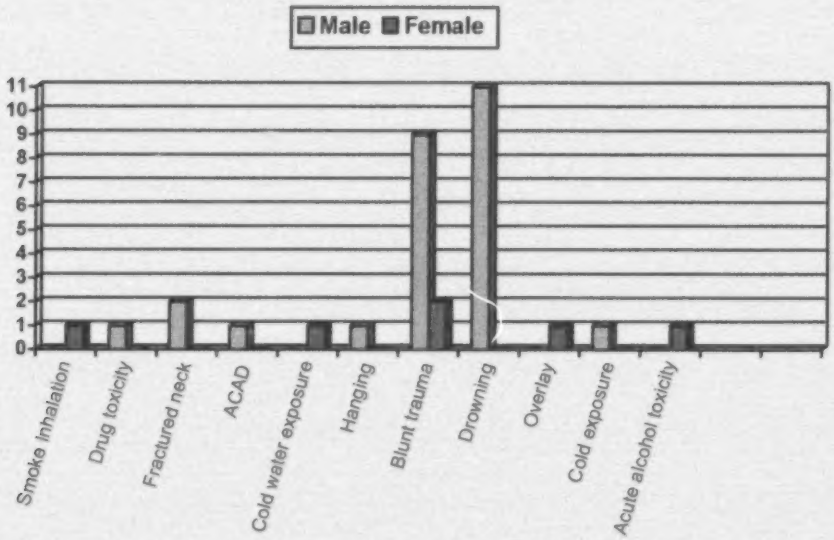
Hanging and firearms each accounted for 2 of the 4 suicides in 2006

SUICIDES BY MONTH 2005 - 2006 COMPARISON



JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
				1		1	1		1			4
				25%		25%	25%		25%			100%

ACCIDENTAL DEATH BY CAUSE/GENDER



Cause of Death	Male	Female	Total	Alcohol Related
Smoke inhalation		1	1	1
Drug toxicity	1		1	
Fractured neck	2		2	1
ACAD (atherosclerotic coronary artery disease)	1		1	
Cold water exposure		1	1	1
Hanging		1	1	
Blunt trauma	9	2	11	4
Drowning	11		11	6
Overlay		1	1	
Cold Exposure	1		1	1
Acute alcohol toxicity	1		1	1
TOTALS	**26**	**6**	**32**	**15**

Accidental deaths accounted for approximately 30% of all deaths reported to the Coroner's Service in 2006. The majority of the deaths (26 of 32, or 81.2%) were males.

Drowning was the cause in 11 of the 32 accidental deaths. (34.5%)

SUDDEN INFANT DEATH SYNDROME

Sudden Infant Death Syndrome (SIDS) is the most common cause of death in infants between 2 weeks and 6 months of age. The finding of a death by SIDS is done by exclusion of any other identifiable cause. The actual reason why these previously healthy infants die suddenly and unexpectedly is not currently known but research is ongoing.

There were 2 reported deaths by SIDS in 2006. Both were males, one approximately 4 months old and the other was 8 months old.

NATURAL & NON-CORONER CASES

Natural	Non-Coroner	Coroner
66	27	39

Under the *Coroners Act*, the Coroners Service is responsible for investigating all sudden, unexpected and unexplained deaths. This does not include palliative care deaths, still births (if attended by a medical practitioner) or deaths that occur in another jurisdiction (i.e. medi-vacs) unless as a result of an incident that occurs in the NWT. A Report of Non-Coroner is issued when a death that is not covered by the *Coroners Act* is reported to a coroner.

All cases deemed as Non-Coroners must be "expected deaths" and must occur by a natural disease process.

AUTOPSIES

JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
3	3	7	1	0	7	6	5	5	3	4	2	46

A post mortem is conducted when the cause and/or manner of death cannot otherwise be determined or when it appears appropriate to conduct the procedure. The autopsy may also be a means of determining the identity of the deceased.

A total of 46 autopsies were conducted in 2006.

CORONER APPOINMENTS

The Office of the Chief Coroner has the statutory authority to recommend the appointment and removal of coroners. It is desirable for each community to have local coroners, therefore recruitment of local coroners is done by the Coroner's Office, the Municipality or Band and the RCMP. Candidates must complete an application form outlining any special skills or training that they have which would assist them in the position of coroner. Applicants are also required to have written support from their Municipality or Band office and their local RCMP detachment. The letters of support and a recommendation of appointment by the Chief Coroner, are then sent to the Minister of Justice for appointment. The applicant's MLA is also notified of the intended appointment. Coroners are appointed by the Minister of Justice for a three year period.

Currently there are 38 Coroners across the Northwest Territories; 18 are aboriginal. There are 25 male (11 aboriginal) coroners and 13 female (7 aboriginal) coroners.

The Coroners and the communities in which they reside are as follows:

Fort Liard - Alan Harris, John Chalk

Fort Smith - Pat Burke, Sandy Napier, Murray Scott, Don Tourangeau

Fort Simpson - John Herring, Peter Shaw, Steve Catto

Hay River - Doug Swallow, Brian Johnson, Jim Forsey

Deline - Elizabeth Takazo

Fort Good Hope - Tommy Kakfwi, Ester Charney

Tulita - Edward McPherson Jr.

Aklavik – Arnie Steinwand

Inuvik - Maureen Gowans, Gerry Kisoun, Brian Fraser MacDonald

Norman Wells - Dudley Johnson, Valerie McGregor

Tuktoyaktuk - Anita Pokiak, Barney Masazumi

Lutselk'e – Alfred Lockhart

Wha ti - Carolyn Coey-Simpson

Tsiigehtchic – James Andrew Cardinal

Yellowknife - Bethan Williams, Garth Eggenberger, Jennifer Eggenberger, Wendy Eggenberger, Fred Whittlinger, Percy Kinney, Cathy Menard

Sachs Harbour - John Keogak

Fort McPherson - Jamie Lee Carpenter, Winnie Greenland

Colville Lake - Wilbert Kochon

Fort Providence - Robert Head

CONCLUDING CORONERS' INVESTIGATIONS

REPORT OF CORONER

All coroner cases are generally concluded by either a Report of Coroner or by Inquest. The most common method used is the "Report of Coroner".

The Report of Coroner is a document outlining the results of a coroner's investigation. It provides clarification of facts and circumstances surrounding the death. The Report establishes the identity of the deceased, classifies the death, and includes any recommendations that may prevent a similar death. A Report of the Coroner and a Report of the Chief Coroner are completed in all death investigations with the exception of cases where an inquest has been called. At Inquest, the Jury Verdict takes the place of a Coroner's Report.

Recommendations are often made and are forwarded to the appropriate department, person or agency in hopes of providing valuable information that may prevent a similar death. Coroner Reports, containing recommendations, are distributed as required and responses are monitored. A synopsis of selected Coroner's Reports containing recommendations is attached. (See Appendix "A")

INQUESTS

Coroner cases that are not concluded by a Report of Coroner are ordinarily finalized by the use of a Coroner's Inquest which is a quasi-judicial hearing held in an open forum. The proceeding utilizes a 6 panel jury and hears testimony from sworn witnesses. The inquest is not a mechanism to resolve civil disputes nor is it used to conduct prosecutions. It is a fact finding proceeding which provides information and recommendations.

A coroner must hold an inquest when the deceased was involuntarily detained in custody at the time of the death. An inquest can also be held when, in the opinion of a coroner, it is necessary to:

a) identify the deceased or the circumstances of death;

b) inform the public of the circumstances of death where it will serve some public purpose;

c) bring dangerous practices or conditions to the knowledge of the public and facilitate the making of recommendations to avoid a preventable death; or

d) inform the public of dangerous practices or conditions in order to avoid future preventable deaths.

If a coroner determines that an inquest is not necessary, the next of kin or other interested person may request that an inquest be held. The Coroner shall consider the request and issue a written decision. This may be appealed to the Chief Coroner, who shall consider the merits of the appeal and within 10 days of receipt of the appeal, provide a written decision with reasons. Subject to the power of the Minister of Justice, under section 24 of the *Coroners Act*, the decision of the Chief Coroner is final.

There was one Inquest held in the Northwest Territories during this reporting period. (See Appendix "B")

APPENDIX "A"

SUMMARY OF SELECTED

CORONERS' REPORTS

(CONCLUDED IN 2006)

CONTAINING

RECOMMENDATIONS

CASE # 1

A 68 year old woman with a history of type II diabetes, a recent knee replacement surgery, a right sided CVA in 2000, TB, hypertension, COPD and a number of other suspected ailments, was found dead in her residence by family members a few hours after being treated and released at the local health centre.

According to medical notes, the family notified the nurse on call very early in the morning, however no action was taken until a second nurse was informed of the death about an hour later. The coroner's office and the RCMP were then notified of the death.

Police and a nurse attended to the home of the deceased. She was noted to be lying in the bed, arms to her side. She was covered with a blanket and there were no signs of any struggle and no indications of any foul play. She was absent any vital signs and death was declared at approximately 8:30 am.

The investigation revealed that the deceased had been brought to the health centre the night before her death, complaining of abdominal pain, nausea and vomiting. She was given Gravol® and Tylenol® 3. She returned later in a weakened condition with the same symptoms. The health record indicates she was given 50 mg of Demerol® (i.e. meperidine) and 50 mg of Gravol® (i.e. diphenhydramine) as well as 5mg of morphine at approximately 3:00 am.

Medical notes indicate that the woman was feeling better and requested to go home to rest. Family recollections are that she was told to go home and rest. In either case, the woman was transported on a backboard to her home and placed in her bed. She was found dead a few hours later.

An autopsy was ordered to be held in Edmonton and the body of the deceased was prepared and transported to Alberta for the procedure.

At Autopsy, there was significant narrowing of the blood vessels that supply the heart (i.e. atherosclerotic coronary artery disease). The blockages were up to 90% in some areas. There was evidence of pulmonary edema and congestion. There was also evidence of the formation of atherosclerosis in the aorta. There were no injuries present to cause or contribute toward the death.

Toxicology was negative for any alcohol. Therapeutic levels of codeine (i.e. a narcotic pain reliever), meperidine (i.e. a pain reliever) and normeperidine (i.e. a breakdown product of meperidine) were found in the samples.

There was no morphine detected but there was a significantly high level of diphenhydramine (i.e. a medication found in Gravol® and other medicines") found in the blood. The level was not high enough to cause death but would have some toxic effects. Since the health records only reflect therapeutic levels given to the deceased, it remains unknown as to where or when she obtained and consumed additional quantities of the medication. It is also unknown as to why the woman was not given the morphine as indicated in the medical chart.

Although not directly related to the cause or manner of death in this case, concern was raised over the level of treatment provided and several questions were put forward to the health authority regarding the "missing" morphine and other reports of "missing" medication.

The nurse at the centre of this circumstance no longer works in the NWT and has had her licence to practice suspended by the issuing jurisdiction.

A meeting was held with the family of the deceased, the Chief Coroner and several health care professionals to outline where the health care system may have failed and what directives have been put in place to ensure that the circumstances regarding her care are not repeated. The Office of the Chief Coroner supports the new initiatives and recommends that they be considered for use by all NWT health authorities.

CASE # 2

In December 2005, a 27 year old man and a 32 year old man were the operators of a pair of snowmobiles that crashed head on while travelling on a frozen lake. Other snowmobile operators travelling with the men were on the scene within moments and noted no pulse or respiration detected on either victim. RCMP, EMT's and the coroner were notified and representatives from these agencies attended the scene.

Police arrived on the scene and noted a wide spread debris field and two deceased males lying in the snow. Photos were taken of the scene and witness statements were obtained by the police. Damage to the two machines was extensive and was consistent with a high speed head on collision

The bodies of the two men were prepared and transported to a local hospital morgue where additional photos and examinations were undertaken.

Both snowmobiles were seized along with helmets and other items and debris. The machines would undergo a mechanical inspection to determine their status and operating capability.

It was determined that very little evidence regarding snowmobile tracks or skid marks were discernible or preservable because of the condition of the lake surface due to deep snow and traffic. Therefore a Traffic Collision Analyst was not summoned to the scene, however, one would be utilized later to help determine the operational status of the brakes and lamps of the two machines.

The investigation revealed that the two men were members of a larger group that had been drinking and snowmobiling throughout the late evening and early morning. The conditions at the time of the incident included an extremely dark sky do to overcast and misty conditions with a temperature of - 4 to -9 degrees Celsius

At approximately 4:00 am the group stopped for a few moments. Two of the snowmobilers decided to race across the lake. When they reached the shoreline, the pair swapped machines and took off back in the opposite direction. It was indicated that they were wearing helmets at the time.

The snowmobile that was leading crashed head on with another machine facing in the opposite direction. The driver of the second machine involved in the crash was also believed to be wearing a helmet at the time of the incident.

There was some initial confusion as to whether both machines were in motion at the time of the collision. It was thought that perhaps one may had stopped on the lake and shut his machine off, thereby disengaging the lights. However, a mechanical inspection of the units and the Traffic Collision Analyst's Report indicate that the taillights and brakelights on the snowmobile were on and operational at the time of the collision.

The issue of whether the machine was actually in motion is more difficult to determine. Mechanical tests on one of the machines indicated the speedometer was fixed at 68 miles per hour following the crash. The throttle was engaged as determined by an analysis of the drive belt and clutch.

It could not be determined with any degree of certainty whether or not the other machine was in motion at the time of the impact. In summation, it was concluded that both machines were in good working order, both machines were running at the time of the collision and both drivers were wearing helmets.

Because of the extent of the head injuries, no autopsies were ordered. Toxicology examination and witness statements revealed both deceased had consumed alcohol and were over the legal limit allowed for the operation of a motor vehicle.

Neither driver was reported to have any specific or diagnosed natural medical condition that could have caused or contributed toward the accident

The coroner determined that both drivers died as a result of blunt head trauma suffered in the collision. Acute ethanol intoxication is considered to be a significant contributing factor in the death. The coroner ruled the deaths as accidental.

This tragic incident is the latest in a long line of snowmobile related deaths that occur all too often in the NWT. It remains an issue in the north, that snowmobiles continue to be viewed in a different light than other motorized vehicles.

Drinking and driving or racing on snowmobiles appears to be more socially acceptable in our society than drinking and driving an automobile. The coroner's office contends that part of that perception is the lack of comprehensive snowmobile legislation in the north.

The coroner's office renewed it's recommendation that the GNWT Department of Transportation draft and implement effective and comprehensive snowmobile legislation throughout the NWT.

CASE # 3

A 23 year old man was one of 4 canoeists travelling on the Kakisa River up stream from the Lady Evelyn Falls. There were two individuals in each of two canoes. The canoe containing the deceased and one other individual capsized shortly after passing through a set of rapids. Both men were caught in a whirlpool for approximately ½ hour.

The other canoeist managed to swim to shore while the decedent continued to fight to escape the rapid flow of water. Although significant effort was made to rescue the man, it was noted that shortly thereafter he was seen face down at the same location and later to have travelled further down the river.

RCMP and an ambulance were contacted to provide assistance to the survivor and to search for the missing man. A helicopter was requested and landed at the site and provided a brief search of the area. However, there was no sign of the decedent.

It was decided to continue the search the next morning. Shortly after the search was renewed, the body of the decedent was noted to be floating, face down approximately 4 metres from shore and about 3-5 kilometres down stream from where the canoe capsized.

Police noted the individual was wearing shorts, a shirt and a life jacket. The water temperature was estimated to be very cold and likely only a few degrees above freezing. Photographs were taken throughout the search and during the discovery of the remains.

The body of the decedent was placed in a body bag and transported to the nearest community Hay River where it was placed in the care and control of the local coroner.

Because the event was witnessed, no autopsy was ordered. A cursory external examination of the body indicated a trauma injury to the head of the deceased. The injury was thought to have occurred either while the deceased was fighting the rapid flow of water or may have occurred during his travel down river and over the Lady Evelyn Falls.

There was some noted trauma to the deceased foot which was consistent with the witness statements suggesting he may have had his foot "caught" while trying to escape the rapids.

An X-ray of the deceased head indicated no skull fracture and no indication of any internal head injury.

Toxicology tests for alcohol and intoxicating drugs was negative.

The coroner determined that the man died as a result of drowning. His subsequent head injury and hypothermia were thought to be contributing factors in his death.

The death had been further classified as accidental.

The coroner indicated that although the deceased was wearing a PFD (i.e. personal floatation device), the type of device used would offer little protection against hypothermia given the very low water temperature. He also noted that helmets were not used by the canoeists in spite of the fact that the waterway they were engaging was shallow in areas and very rocky. Such equipment was offered by a local outfitter but declined.

With the canoeing/boating season just a short time away, it was felt that a recommendation to the Government of the NWT and the federal Office of Boating Safety, would be appropriate in asking them to renew and enhance their efforts on water safety awareness programs in the NWT.

SUMMARY OF

CORONERS' INQUESTS

(CONCLUDED IN 2006)

CONTAINING

RECOMMENDATIONS

INQUEST # 1

An Inquest into the death of Kenneth Moore McFee, who died on July, 24th 2006 was held in Courtroom #1 of the Yellowknife Court House.

Mr. McFee was a resident of the Northern United Place apartment complex in Yellowknife. On the evening of July 23rd, 2006, Mr. McFee entered elevator # 2 on the fifth floor. One other male occupant was on the elevator when Mr. McFee entered. The elevator door closed and the elevator proceeded down toward the lobby.

A few moments later, the city of Yellowknife was hit with a power blackout which caused the elevator in which Mr. McFee and the other occupant were riding, to become stuck between the third and forth floors of the building.

The elevator was not equipped with a telephone or other communication devise. The emergency alarm button was in place and was used by the trapped individuals to notify building security.

The elevators in the building are equipped with an emergency power source which will allow each of the two elevators to be powered during a blackout, but only one elevator at a time can be selected to engage the power source.

A keyed switch designed for this purpose is located on the wall between the elevators on the first floor. The unit was in the off or neutral position at the time of the power failure.

Security personnel made contact with the trapped individuals and informed them that efforts were being made to secure their release.

A security officer was informed that there was a key to the power transfer switch in the main office of the building and was instructed to retrieve the key and affect a power transfer to elevator number 2 to allow the elevator to continue it's intended journey down to the lobby.

An attempt was eventually made to transfer the power but the keyed switch would not turn. A locksmith later reported that the switch was in proper working order but the key was faulty and would only operate if fully inserted and then pulled back about 1/8th of an inch.

During the time the key in question was being sought after and applied, *(about 15-20 minutes)* the occupants of the elevator were able to push open the elevator car door and gain access to the third floor landing door. By overriding the manual door latch, they were able to open the landing door as well.

The other occupant of the elevator slipped through the narrow opening and set down on the 3rd floor landing. As Mr. McFee attempted to exit the elevator car, he slipped, struck the third floor landing and fell forward (under the elevator car) into the open elevator shaft. He suffered significant internal injuries as a result of the fall.

Ambulance personnel arrived on the scene shortly thereafter along with building officers, the RCMP

and a representative from the Elevator maintenance company. The first floor landing door was opened and Mr. McFee was removed from the shaft and transported to Stanton Territorial Hospital where he was pronounced dead in the early morning hours of July 24th, 2006.

The inquest focussed on areas involving elevator inspections, servicing, testing and current legislation.

The inquest heard from 12 witnesses and 41 exhibits were entered as evidence. The jury deliberated for approximately 4.5 hours before returning their unanimous decision.

They determined that Mr. McFee died on July 24th, at Stanton Territorial Hospital. The cause of death was determined to be, multiple blunt trauma and the death was ruled accidental.

The jury made a total of 18 recommendations regarding the death of Mr. McFee. They are listed below as they appear on the original verdict form. (The words in *italics* following each recommendation are the opinion of the Chief Coroner as to the jury's rationale and are provided to assist the reader in understanding the recommendation. They are not to be considered as an actual component of the inquest.)

1. ***To the GNWT: Amend current Legislation to mandate that all passenger elevators in the Northwest Territories be modified to meet current code standards in regards to door restrictors on the car doors, and be implemented no later than one year after legislation is passed.*** *(The jury heard testimony that the elevator in question was only required to meet the elevator codes in place in 1975 and that the unit was not currently required to meet the current code which calls for elevators to have door restrictors in place in ensure that the car door cannot be opened from inside the elevator car. The jury felt this legislation should be changed in the interest of safety).*

2. ***To the GNWT: Amend current legislation to ensure that any keys required for the operation of an elevator or any emergency equipment are created by a certified locksmith and tested, and that all subsequent keys are to be created and tested in the same manner.*** *(The jury heard testimony that the power transfer key likely malfunctioned because it was probably created on a duplicating machine and may have been a copy of a copy which can result in a imperfect duplication. It was felt that the use of a locksmith would minimize any possibility of a copying error. It was also determined that no prior testing of any of the keys available had been documented. The jury felt that legislation in this area may be beneficial in ensuring that emergency keys operate as expected.).*

3. ***To the GNWT: Amend current legislation to mandate all passenger elevators in the Northwest Territories to have a telephone or intercom system installed and monitored 24 hours a day.*** *(The jury heard testimony that the 1975 legislation that the current elevator was allowed to be operated under does not require this function. It was felt that if such communication was possible, better direction and communication with the trapped individuals may avert a similar situation).*

4. ***The jury recommends that as a temporary measure*** *(until legislation is amended)* ***a universal symbol be placed on the top and bottom of the interior face of the hall door as a caution to passengers, not to attempt to open the hall door.*** *(The jury felt that such notices might help prevent someone from continuing to attempt to exit a stuck elevator. It was not clear to whom this recommendation was to be made or whether it was suggested as a voluntary gesture or to be legislated. It therefore could be considered by the GNWT, the building owners/managers or the elevator maintenance company.).*

5. *To the NWT Fire Marshal and electrical Inspector: perform or delegate an audit and inspection of all elevators in the Northwest Territories, operating with remote power switches, to ensure that they are operational and that a record be maintained. Inspections to be done twice a year.* *(The jury heard conflicting testimony as to which organization or agency is responsible for checking and maintaining the elevator power transfer switch).*

6. *To the Northern United Place building manager: We (the jury) recommend that it be the building manager's responsibility, on a monthly basis, to check that all keys in distribution, remain functional,* *(The jury noted that there is no current policy or practice regarding the testing of emergency keys).*

7. *To the Northern United Place building manager: All keys required for the operation of emergency equipment, be made available to appropriate staff in buildings where elevators are installed and that they be available in a convenient location to all emergency responders. The keys should be clearly labeled.* *(The jury heard that security personnel were not immediately aware of the location or operation of the power transfer switch and that the local fire department did not have any independent access to the key.).*

8. *To the Northern United Place building manager: The jury recommends that an advisory card be installed outside each elevator, indicating emergency numbers to call if there are passengers stuck in an elevator and a warning to potential rescuers not to attempt to open the doors to release the passengers inside..* *(The jury noted there was no such notice or warning currently displayed.).*

9. *To the NWT Community Services Corporation: The organization should complete as soon as possible, any and all safety modifications to the elevators in Northern United Place that are recommended by their contracted elevator maintenance provider.* *(The jury heard testimony regarding elevator upgrades and safety warning notices that were made available to the building owners but were not slated for immediate implementation).*

10. *To all building operation managers in the NWT: All building operation managers provide operational and emergency training, both general and specific, to all security personnel to the building in their charge.* *(The jury heard testimony that no general or specific emergency training was provided to security staff at Northern United Place. The jury felt that such training and information be provided on a universal scale in the NWT).*

11. *To the GNWT: Adopt a policy to send out by mail and by electronic mail, "Safety Bulletins" to all elevator operator/licence holders as well as posting it on the government website.* *(The jury heard evidence that the general practice is to only post the bulletins on the web site. It was felt that a more pro-active approach to deseminating the information was appropriate).*

12. *To the GNWT: The government should conduct a review of public education on elevator safety by the authority having jurisdiction.* *(The jury was made aware of a previous public education initiative and felt the concept should be explored further. This recommendation also mimics one made by the Chief Elevator Inspection in his report of this incident.).*

13. *To NWT Security Providers: All security providers provide to all of their security personnel, operational and emergency training, both general and specific to the building in their charge.* *(This recommendation basically mirrors recommendation number 10 above, but is directed to the security companies themselves.).*

14. *To Thyssen-Krupp Elevator Limited: The maintenance company , in conjunction with The Fire Marshal, the Chief Elevator Inspector and the local Fire Departments, facilitate information sessions specifically designed for building owners to inform and ensure awareness of; a) best practices in the industry for elevator safety and maintenance. b) owners responsibilities and record-keeping (including checklists) required, and to properly discharge these responsibilities.* *(The jury felt that some of the requirements for record keeping and testing were not properly communicated between several organizations and it was unclear as to who might be responsible for certain tasks. It was felt that a meeting/training session involving all parties might be beneficial).*

15. *To the NWT Fire Marshal: Establish a regulation or order within the Fire Marshal's office, an on-going auditing program to verify compliance with those matters which are an owner or owner's agent responsibilities under the compliance parts of C.S.A. B-44 and the national Fire code as well as the Fire Prevention Act and Regulations.* *(The jury was made aware that some requirement, inspections and verifications mandated under legislation were not being applied universally. It was felt a more accurate and formal auditing program would improve this component of the process).*

16. *To the Northern United Place building manager: The jury recommends, as a temporary measure that building personnel have written policies to their staff directing that staff make every effort to locate the elevator car and prevent an attempted exit of trapped parties until restrictors are installed.* *(The jury felt this practice might be helpful until legislation regarding door restrictors is passed and implemented).*

17. *To the GNWT: The jury recommends the education program of the Regulatory Authority with respect to elevator safety be better financed and better supported by building owners, government, elevator maintenance contractors and all other interested parties.* *The jury appears to be calling for more resources and partnerships in regards to awareness training similar to what is mentioned in recommendation number 12 above).*

18. *To Thyssen-Krupp Elevator Limited: To work with building operation managers to clearly communicate what role each plays in maintaining the elevators. This should be clearly stated in a written contract and adhered to.* *(The jury heard conflicting testimony as to who might be in charge of certain components of the inspection process. It was felt that a meeting between the maintenance contractor and the building manager would clear up any confusion and insure that all checks and inspections are being properly and diligently performed).*

REPORTING OF DEATHS

Duty to Notify

8. (1) Every person shall immediately notify a coroner or a police officer of any death of which he or she has knowledge that occurs in the Territories, or as a result of events that occur in the Territories, where the death

(a) occurs as a result of apparent violence, other than disease, sickness or old age;

(b) occurs as a result of apparent negligence, misconduct or malpractice;

(c) occurs suddenly and unexpectedly when the deceased was in apparent good health;

(d) occurs within 10 days after a medical procedure or while the deceased is under or recovering from anesthesia;

(e) occurs as a result of

(i) a disease or sickness incurred or contracted by the deceased,

(ii) an injury sustained by the deceased, or

(iii) an exposure of the deceased to a toxic substance, as result or in the course of any employment or occupation of the deceased;

(f) is a stillbirth that occurs without the presence of a medical practitioner;

(g) occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution; or

(h) occurs while the deceased is detained by or in the custody of a police officer.

Exception

(2) Notwithstanding subsection (1), a person need not notify a coroner or a police officer of a reportable death where the person knows that a coroner or police officer is already aware of the death

Duty of police officer

(3) A police officer who has knowledge of a reportable death shall immediately notify a coroner of the death.

Special reporting arrangements

(4) The Chief Coroner may make special arrangements with medical facilities, correctional facilities and the Royal Canadian Mounted Police for the efficient notification of reportable deaths by persons in those facilities or that organization.